Informed Consent for Telemedicine Services

Patient Name: _________________________________ Date of Birth: ________________

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s) and/or service(s)
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2. NATURE OF TELEMEDICINE CONSULT: The primary difference between telehealth and direct in person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination**. OUR PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES VIA TELEHEALTH. IF YOU BELIEVE YOU ARE EXPERIENING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCEY ROOM.**

3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur.

4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Tennessee state law apply to information disclosed during this telemedicine consultation.

5. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment.

6. ACKNOWLEDGEMENTS: I understand that alternatives to telehealth consultation, such as in person services are available to me, and I fully consent to conducting this consultation via telehealth.

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7. PAYMENT OF SERVICES: You agree that Women's Surgery & Aesthetics Center reserves the right to bill a telemedicine visit to your respective insurance company. As well, you are responsible for any patient portion of the telemedicine consult, before your telemedicine consult will be scheduled. If your insurance will not cover telehealth services, you will be responsible for payment.

8. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above. I agree to participate in a telemedicine consultation for the procedure(s) described above.

Signature: ____ Date: ________________